

the uterus may coexist and give rise to characteristic symptoms, yet these are not the main features in the case, the real trouble being general prolapse of the bowels. It is possible that many phenomena, such as chlorosis, hyperæmia gravidarum, menstrual disorders, etc., are really symptoms of enteroptosis (*enteroptosische Krisen*). Many women never feel so well as during the later months of pregnancy, when the prolapsed abdominal viscera are replaced in their normal position by the pressure of the enlarging uterus (!). The frequent inclination of the gravid organ toward the right is due to gastroptosis, and many gastric symptoms regarded by gynecologists as hysteroneuroses are undoubtedly due to the same displacement of the stomach.

[It is impossible to accept this theory in sober earnest. With all due deference to the writer's keenness of observation, it would seem as if he were seeking to push a recent "fad" to the extreme limit.—H. C. C.]

NEW OPERATIONS FOR STENOSIS OF THE OS UTERI.

VULLIET (*Centralblatt für Gynäkologie*, 1894, No. 3) describes and figures an ingenious plastic operation for antelexion and stenosis, the steps of which are as follows: With the patient in the dorsal posture the cervix is drawn forcibly downward and backward, and an incision is made at the vaginal junction, encircling the left half of the cervix. The vagina and bladder are separated as high as a point above the angle of flexion. The cervix is then split anteriorly up to this point, the bladder being held out of the way with a sound, and the uterus in a position of anteversion by another sound. A second incision around the cervix in the line of the crescentic incision is then made, forming a flap, which is then turned upward and sutured between the edges of the vertical cut, after which the vaginal wound is closed. A large sound can now be passed readily, and it will be found on examination that there has been a notable correction of the stenosis at the point of flexion.

BORYSSOWICZ (*ibid.*) commends this procedure for simple stenosis of the os externum on account of its easy execution, painlessness, and permanent results. Drawing the cervix downward and backward, he introduces a special fenestrated sound into the cervical canal. A curved needle carrying a double silk suture is passed transversely through the cervix an inch above the os externum, traversing the opening in the sound. The latter is then withdrawn with the ligature, which is divided, and one suture is tied tightly with a surgical knot on either side and is cut short, the other two being tied loosely at first, and gradually tightened four or five days later. The vagina is tamponed with gauze, the patient being kept in bed for three or four days. Daily vaginal irrigation with bichloride solution is employed, and the ligatures come away at the end of two weeks, when the os will be found to present a transverse fissure.

SENILE ENDOMETRITIS.

JACOBS (*Polyclinique*, 1893, No. 10) does not believe that the menopause exerts a curative influence upon endometritis and resulting leucorrhœa. Endometritis after the climacteric may be accompanied by a malodorous discharge, which might readily awaken the suspicion of malignant disease, especially if the patient presents also emaciation, pain, and visceral disturb-

ances. Eczema, acne, or pruritus vulvæ are frequently present, and mucous polypi of the cervix are found not infrequently. The writer recommends curettage.

PATRU (*Revue Méd. de Suisse Rom.*, 1893, No. 5) compares purulent senile endometritis to ozæna. It usually occurs in women over sixty, and is sometimes of bacterial origin. The uterus may be of normal size, and not especially sensitive to pressure, though the introduction of a sound causes much pain. The patient may complain of pains in the back and pelvis. Her bad appearance, together with the foul vaginal discharge, may seem to point to cancer of the corpus uteri, though the examination shows nothing suspicious. Vaginitis is often present, and sometimes cicatrices—in fact the so-called “adhesive vaginitis” may be secondary to the purulent endometritis. The prognosis is favorable, since the affection tends to disappear spontaneously with advancing years. Malignant degeneration has not been noted as a result of senile endometritis; sepsis from prolonged suppuration is, however, a possibility. The treatment recommended is dilatation, curettage, and cauterization of the endometrium, with frequent antiseptic vaginal injections.

INOCULATION WITH CANCER.

SIPPEL (*Centralblatt für Gynäkologie*, 1894, No. 4) reports several cases which seem to confirm the now generally accepted view that healthy tissue may be inoculated by simple contact with a malignant growth. In one case a small circumscribed nodule was found behind the posterior commissure, where the cancerous cervix of a prolapsed uterus had rested upon it, the vaginal wall being elsewhere perfectly healthy.

In another an apparently simple multilocular ovarian cyst was removed, suspicious material from a secondary loculus escaping into the peritoneal cavity. The peritoneum was healthy. The patient was discharged in March perfectly well; but returned in October of the same year with extensive ascites, cancerous infiltration at either side of the cicatrix, at the sites of the sutures, and multiple nodules in the peritoneum, the nature of which was proved by an explorative incision. The presence of the minute cancerous nodules developing in the fascia at the needle-punctures seemed to support the theory of infection from the fluid which entered the peritoneal cavity at the time of the first operation.

A further proof that the constriction of the tissues by a suture may cause such a change in them as to furnish a *locus minor resistantiæ* for the development of secondary carcinoma seemed to be furnished in a case of vaginal hysterectomy, in which a piece of silk was found in the centre of a recurrent nodule in the cicatrix.

THE DIAGNOSTIC VALUE OF UROBILINURIA.

MANDRY (*Archiv für Gynäkologie*, Band xlv., Heft 3) summarizes the results of his observations as follows: In healthy puerperæ no excess of urobilin is noted in the urine, the reverse being the case after obstetric operations and laceration of the perineum. As a rule, urobilinuria is not present after minor gynecological operations, but only after difficult cæliotomies. It